



Abstinence – treatment, philosophy and methods

In this two-part article Dr Gordon Morse puts the spotlight on the relationship of abstinence, harm reduction and the 12 Step philosophy. As something often aspired for, sometimes elusive and sometimes achieved by drug users, this article is an important reminder that the practitioner and the individual patient need a full spectrum of prescribing and treatment options from maintenance to abstinence approaches. In our next issue, Gordon will look at detoxification and methods of supporting enduring abstinence. Ed.

Abstinence and harm reduction – two sides of the same coin

Drug users come from all walks of life, and all have different stories and different

journeys. Similarly their aspirations and the way in which they are going to achieve them vary. But pretty nearly all, at some time, want abstinence.

After the initial honeymoon period, most drug users want abstinence almost every day of their using careers – certainly 57% of drug users accessing treatment services for the first time said that abstinence was the only change that they hoped for against 15% opting for harm reduction [1]. The problem of course is that only about 5% of heroin dependant patients each year achieve durable abstinence. For those who attempt abstinence but then relapse, there is the sense of shame and failure which can provoke even more drug use, and the very real risk of loss of tolerance leading to overdose. So why is it so difficult to achieve, and once achieved, why is abstinence so difficult to sustain?



...continued overleaf

In this issue

Abstinence as opposed to maintenance has been a lot in the news recently. Gordon Morse in the first of 2 articles squares the circle between these 2 concepts that should be complementary but are so often perceived not to be. **Pages 1-3.**

Are you concerned about incorporating formal **care planning** into your clinical practice? Susi Harris gives the full lowdown on **pages 4-5.**

Shooting up report, pages 6-8. A report to guard us against complacency, Vivien Hope and *Susie Huntingdon* highlight the continuing increase in HIV prevalence and an increase in injection risk behaviour.

There is good news in the **NICE guidance on Hepatitis C treatment, pages 7-8** which should make treatment more accessible to more patients as long as screening effectiveness is improved. Hopefully this is a significant move forward but all is not rosy in the primary care PCT back yard where a public health time bomb awaits....

Charlotte Tompkins, Laura Sheard and Nat Wright have conducted a fascinating study on **women users injected by other users, page 9**, resulting in clear and useful clinical implications. On the back of our articles on *Shooting Up* and on increasing HIV and Hepatitis prevalence and risky injecting practices, this is a must read.

Following on from the last issue we have 2 practical examples of the use of **practice based commissioning** in the substance misuse field from *Clive Jekyll* and *Steve Skinner*. Its here and its happening! **Pages 10-11.**

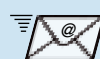
Also following on from the last issue we have the second part of *Nigel Modern's* intriguing investigation into **supervised consumption** as a tool for dose induction and assessment. **Page 12.**

Dr Fixit spoils us this issue, with **drug and alcohol abstinence** by Gordon Morse **page 13**, **alcohol detox** by *Jeff Fernandez*, and **shift work and methadone** by *Chris Ford* and *Kim Wolff* on **page 14** and a related exercise and methadone piece by *Kim Wolff* on **page 15.**

We hope you enjoy this issue.

Jean-Claude Barjolin

Editor



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Editorial



SMMGP funding reduction – new times

As many of you may be aware SMMGP has had a significant reduction in its central funding from the DH. This has meant that we have had to focus in on our core business of being a clinical network for primary care substance misuse. From now on we this is where all our attention will be focused. We are sure that the network itself will continue to grow and thrive. As part of this shift in focus we are becoming a membership organization. To see what that entails and its benefits for you please read page 15 and membership insert ... and please join (for free!). With uncertainty in the field, a formal membership will support the network and work in the future so please do support. Unfortunately we will no longer be able to deliver hands on advisory services but the web-site, newsletter, networking and information services will continue as before.

Support SMMGP as a membership organisation

Become SMMGP member – this is free of charge but important to allow the network to continue and to thrive – read page 15 for details and please complete our enclosed form (www.smmgp.org.uk/membership) and user questionnaire (www.smmgp.org.uk/network) in order to help us maintain the quality of the newsletter.

Your support is appreciated.

Sadness at SMMGP staffing cuts -

Due to funding reductions and re-contracting, SMMGP has sadly had significant staff reductions. We would like to thank Kate Halliday, and Annas Dixon, who have both recently left the project, and Christina McArthur and Mark Birtwistle who will be leaving in the new year, for their fantastic contribution to the field and to the project. We will miss them and are saddened by the difficult re-contracting process and circumstances that have led to this. We wish them every success for the future.

April 19th & 20th National Managing Drug Users in Primary Care Conference, Birmingham www.smmgp.org & www.healthcare-events.co.uk Don't forget to get your paper, audit, poster or film in!

...continued from front page

Many people who have never experienced addiction ask these questions, and faced with the awful consequences of a roaring drug dependency (which we all know and which I will not therefore repeat) it does seem perverse that someone would go through the uncomfortable business of a detox, and then "fecklessly" relapse. So it may be worth considering the reasons behind this apparent paradox.

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I would begin by patronisingly suggesting that most drug users don't actually want the full consequence of abstinence; what they want is an end to the chaos– the daily worry and reality of feeling sick, being pursued by debt collectors, the police, the chronic pain and unhappiness of lost relationships, children taken into care and so forth, the daily obsession with needing first the money and then the drug, just to feel normal – abstinence is seen in only one half of its reality – the riddance of all that is wrong with drug use. But of course abstinence has two halves, it also demands the riddance of all that is *right* with drug use.

Drug users are very good at what they do – for most of their adult lives (and often longer) they have become skilled in resourcing their habit by whatever means – they are socially bonded to a peer group or partners who are usually also drug using. All that they have known for years has drug use at its core. And drugs of course also feel good – if they didn't, we wouldn't have the problem.

“Heroin is a sensory deprivation tank for the soul where there is no sense of pain, no regret or shame, no feelings of grief or guilt, no depression and no desire. Insensible stillness and peace disperse fear and suffering.” [2]

Many of our patients are carrying around

a burden of pain from early life traumas, and indeed from the consequences of their drug using – how tempting it must be to slip back into that state which Pink Floyd so succinctly described as “comfortably numb”. The consequences of full-on drug using are indeed horrible, they soon drive the merits of drug use into the distant memory. But the consequences of abstinence soon resurrect those memories, leading to the inevitable question: “Wouldn't it be nice if I could just use occasionally? Just get all the merits, without a dependency.” In a way, this what a methadone script offers. Daily methadone keeps the chaos of full-on heroin dependency at bay, but still allows (assuming the modern non-punitive treatment model) occasional use with relative impunity.

So apparently the harm reduction model affords a safe haven both from the chaos, and from which the patient can occasionally indulge his habit without most of the negative consequences. We all recognise the enormous gains in reduction of morbidity and mortality which good harm reduction programmes have delivered, and must put an end to the pathetic Jurassic arguments that seek to polarise the abstinence versus harm reduction phoney war. Abstinence without the safety net of harm reduction when someone falls off the wagon is dangerous. But equally Harm Reduction must entertain the realistic hope that one day, abstinence can be achieved.

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Because methadone programmes are not perfect. Many studies have seen substantial reductions in drug use accompanied by worrying increases of alcohol consumption. Poly drug use is now far more common than single drug use, and methadone alone is often not enough in complex cases. And I suspect

that the majority of those in harm reduction programmes, whether they are using occasionally or not, will sooner or later prefer to not be dependant upon a drug (be it a safer prescribed pharmaceutical or not), a doctor, a pharmacist and a drug service. They would like to lead what they perceive as “normal” lives, and have their independence back.

Abstinence philosophy and the 12 steps

Earlier I referred to patients ultimately seeking independence from drugs and drug services. We often hear them say “I just want my life back”. There is nothing wrong with being dependant on methadone, purely in the narrow sense of dependency: diabetics are dependant of insulin medication, but they too would rather not be. It is inconvenient, its availability is a permanent source of concern, and travel arrangements can be awkward. But for insulin diabetics, there is no choice – for the drug or alcohol addicted, there is a choice. And every day that they have not returned to abstinence is almost a choice to be dependent.

That can be a hard to accept – that one would choose to stay dependant. Even for the veteran who has detoxed on a number of occasions, who has moved past denial to taking full responsibility for the consequence of his drug using but just cannot stomach the constant fight to maintain abstinence, to admit to yourself that you just can’t do it is a very uncomfortable admission. There is that self-efficacy in all of us that needs to be free and independent; *“If you are not master of your own destiny, some other bugger is”*. [3]

Abstinence is therefore a seismic shift in personal philosophy – it is a symbolic reversal of dependency on drugs and a self-serving life where that dependency and need is at the centre of all relationships, to independence. And the realisation of that independence demands the acceptance of responsibility for everything in your life, and bestows the freedom to appreciate it. It also demands, for most people, the acceptance that you will never be able to regain control. This is what is referred to in 12 Step programmes (e.g., or as otherwise called, Narcotics Anonymous, Cocaine Anonymous, Alcohol Anonymous) as “the acceptance

of powerlessness”. Paradoxically, there is something fundamentally liberating in the acceptance of powerlessness – for it means that you never have to struggle with control again. You just don’t try.

Bear with me whilst I go off at a tangent, because this will illustrate a fundamentally important principle in embracing abstinence: many drinkers resist being labelled “alcoholic”. Actually the word “alcoholic” is seldom used in medicine and has no universally agreed definition. Many heavy drinkers are content to agree that their drinking is adversely affecting their lives in some way, and that they have difficulty with control – most are content to be described as “problem drinkers”, but because they can go for a few days without a drink, or don’t drink first thing in the morning, or whatever other prejudice they have, they are therefore not “alcoholics”. Most have friends who drink as much or more than they do, and are apparently well, and it is that which validates their continued drinking. Most therefore would like to reduce their drinking because they know it is harming them, but they just can’t – it is the continued argument with “not being a real alcoholic” that enables the drinking to continue. They cannot visit their heavy drinking friends and say “Don’t give me a drink because I am drinking a little bit too much”. But once you cross the Rubicon and define yourself as an Alcoholic, someone who is powerless to maintain control, that definition empowers you to deny alcohol consumption.

This concept of the powerless addict is central to the 12 Step philosophy. Once accepted, it is a lifetime status – it is a status that defines the person. It doesn’t have to, and indeed should not permeate every corner of a person’s life, but it is of central relevance wherever mind affecting and addictive substances and your life might meet. And it begins to take on a spiritual dimension as well – not necessarily a religious dimension, although for many in the Fellowships (NA, CA, AA etc) religion is important. But belief is extremely powerful: it does not have to justify itself, it just is. Belief, as they say, moves mountains, and if you accept that you are powerless over something, then a belief that something else can restore you to sanity is extremely powerful. The 12 Steps are a belief system – they demand belief in the concepts in the Big Book, and that adherence to the Steps will keep you sober.

This arbitrary belief system is very difficult for many to accept – indeed it is often very off putting to those early contacts with 12 Step groups. But even the most secular of us have beliefs when it comes to politics, natural law, philosophy or whatever – to adopt a new belief system that offers a way out of the curse of dependency should not be beyond any of us.

“But even the most secular of us have beliefs when it comes to politics, natural law, philosophy or whatever – to adopt a new belief system that offers a way out of the curse of dependency should not be beyond any of us.”

12 Step attendance has been subject to many studies, although for obvious reasons it does not lend itself to scientifically rigorous analysis. But it is evident that it is as powerful in maintaining abstinence as any other modality, be it drug, CBT or whatever. And 12 Step groups are available the world over, free of charge.

In Network 17, the second part of this article, I will look at detox and methods of supporting enduring abstinence.

Dr Gordon Morse

GP Medical Consultant to Clouds House, Trust Specialist and Lead GP Clinician for West Wiltshire Specialist Drug and Alcohol Service, RCGP Regional Lead.

References:

- [1] What Are Drug Users Looking For When They Contact Drug Services: abstinence or harm reduction? Neil McKeganey, Zoe Morris, Joanne Neale & Michele Robertson Drugs: education, prevention and policy, Vol. 11, No. 5, 423-435, October, 2004
- [2] “Shantaram” Gregory David Roberts – Abacus Books 2005
- [3] Quote by Abel Halpern, aged 26 the President and CEO of Texas Pacific, one of the USA’s most successful venture capitalists, after buying out Ducati Motorcycles.

Care planning in primary care ...simple?

The message seems to be 'keep it simple but do it' as the NTA prioritises this area, with 90% care planning targets set for April 2007. A simple plan will need to exist, which the GP can contribute to and remain aware of, albeit using incremental and quick in house methods. This needs to cover evolving holistic care needs across **drug and alcohol use, psychosocial functioning, physical and mental health and crime**. Primary care's ability to embrace technology solutions may prove useful as unified patient records are about to take a leap forward...maybe not so painful after all? Ed.

Introduction

Care planning in primary care is not new, it is alive and working well in chronic disease management in many areas, such as diabetes and asthma.

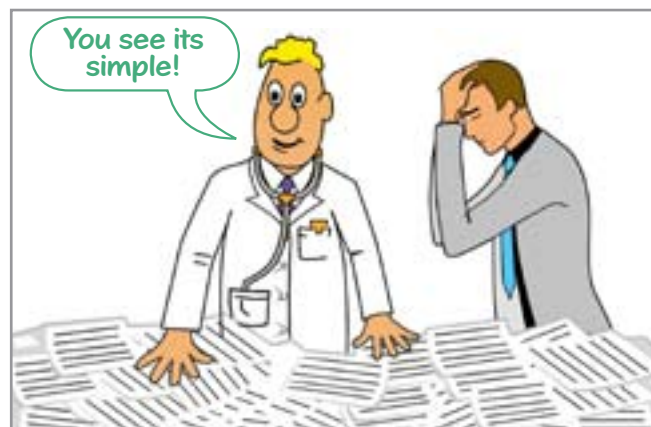
Some GPs may be wondering why there is a new requirement for care planning treatment for their drug-misusing patients, yet the NTA see this as a central plank of their new effectiveness strategy – why are the NTA so keen on it, why are some GPs less keen, and what is care planning anyway?

The National Treatment Agency for Substance Misuse (NTA) is a special Health Authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England. Initially the work programme concentrated on ensuring greater numbers of patients in treatment through its *Models of care for the treatment of adult drug misusers* (NTA, 2002), by improving care pathways, reducing the postcode lottery of treatment modalities, increasing workforce, and enhancing accessibility. This highly successful approach has vastly increased the numbers in treatment, so much so that the original government PSA target for numbers in treatment by 2008 has already been achieved.

However, it is important that simply being in treatment is not seen as an end in itself. Patients almost invariably see treatment as a temporary event, even though they accept that it may continue for a long time before it ends. The 2nd Audit commission report *Drug misuse 2004: Reducing the local impact*, underlined this point, recommending further improvements in psychosocial and health aspects of treatment. Hence the *Models of care for the treatment of adult drug misusers: Update 2006* which focuses on treatment **effectiveness**, emphasising the need for services to deliver not only prescribing but also all the elements of 'wraparound' care which the evidence shows enable patients to move through treatment, and eventually, in many cases, to exit altogether.

Why care planning?

Delivery of a treatment **package**, which can involve not only prescribing and harm minimisation, but also structured behavioural therapies, mental and physical healthcare, family, housing, educational and occupational support, and benefits and nutritional advice, (to name a few) can involve many agencies and caring professionals, and be very confusing for



all concerned. It is possible for certain needs to overwhelm the system, so that others are overlooked. It can be hard also, particularly when a patient is on maintenance treatment, for all involved to see the progress being made in other areas of their life apart from drug misuse, which is moving them towards their ultimate goal of exit. Hence the need, identified in the *Models of care* for a care coordinator, or keyworker to ensure that all needs are being adequately addressed, and appropriately prioritised, and the need for a written plan, with multiagency input, so that all concerned, particularly the patient, can see what steps are being taken, what is being achieved, and what still needs to be done.

What is care planning?

The phrase 'care planning' has different meanings according to context. In asthma and diabetes it may amount to a pre-defined treatment protocol, tailored to the individual, whilst in mental health it could be seen as a risk management strategy. Whilst risk management and treatment protocols are of course important in substance misuse as in any other condition, the care plan in substance misuse is not intended to be prescriptive, rather it is a user-defined action plan with the emphasis on facilitating a **holistic** package of care.

The NTA has identified key principles underlying care planning for substance misuse and these are set out below:

The care plan should be **permanently recorded in the patient's notes**, using a **standard format care planning tool** drawn up by the treatment agency, in writing or as part of computerised record.

The recent HCC improvement review into substance misuse services¹ set the standards for care planning tools. They should be:

- Short, (no more than one side of A4)
- Address all 4 of the following domains: **drug and alcohol use, psychosocial functioning, physical and mental health, and crime**
- Identify clear short-term goals for each domain, and the means to achieve them
- Identify the person responsible for taking each required step
- State the date by which the actions are to be done
- State the date for review (maximum 1 year, but usually much less)

1 <<http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandinspections/improvementreviews/substancemisuse.cfm>>

Services are of course free to continue using existing care planning tools, with the proviso that the 4 domains mentioned above should be included.

The most appropriate person to assist in drawing up the care plan (in conjunction with the patient) is **the person who consults with them most often**. Usually, this will be the keyworker, but it is recognised that historically, some GPs have chosen to act as keyworkers for their patients, and in that case it will be the GP.

Patient engagement in the process of drawing up a care plan is crucial. Patients need to have ownership of the care plan to take responsibility for implementation. It is good practice to ensure that patients sign care plans, and are offered a printed copy to keep.

Prescribers have a responsibility to ensure that a care plan exists before they prescribe, even if this is only a brief initial version drawn up at triage. They do not have to draw up the care plan themselves, but should be able to contribute to it when appropriate. It will no longer be seen as good practice to prescribe in the absence of a care plan.

Why is the NTA so keen on it?

There are several reasons why the NTA sees Care Planning as key to its effectiveness strategy. Clearly there are practical reasons why it is *likely* to help, as mentioned above, and for an inexperienced keyworker, it can be a particularly useful tool to ensure holistic care. Secondly, there is a need to *monitor* delivery - identification of good care planning tools, and care plans in patients' notes are convenient proxy markers of treatment effectiveness, which treatment providers, commissioners and the NTA can use to monitor performance.

But most important is the evidence from the user survey, which showed that patient satisfaction was highly correlated with the knowledge that they had a care plan. It was also seen as important that the care plan was reviewed frequently: to quote from the NTA research briefing 18, published in June 2006 *The NTA's first annual user satisfaction survey 2005*.

"Those clients with a care plan that had recently been reviewed (i.e. in the last three months) were most likely to be satisfied with their treatment. Those clients with a care plan that had been reviewed 3–12 months ago had the next highest satisfaction score, followed by those with a care plan that had been reviewed over a year ago. Clients without a care plan were most likely to be dissatisfied with their treatment experience."²

It does not take long to see why this might be; if one had been consigned to many months of maintenance treatment with no explicit plan, after the initial positive harm minimisation gains, one might feel one had reached a plateau with no end in sight. Most practitioners will have experienced patients who openly express fears around getting 'stuck' on treatment, for instance declaring they 'only want to take methadone for a few weeks' at initiation, or refusing to increase their dose when recommended to do so for fear they will 'never get off it'.

The user survey showed 62% of patients reported that they had a written care plan. That presumably means up to 38% were not aware of plans for their treatment. There is a danger that such patients could feel 'stuck' on their script with no way out. The NTA sees tackling this problem as a priority and has set

challenging targets for patients to have written care plans – 90% by April 2007, and 75% for patients to report having a care plan at the 2007 user survey.

Why are some GPs less keen?

Naturally, GPs are quite familiar with managing long-term, chronic diseases, setting treatment goals and reviewing and resetting goals opportunistically. They are also very familiar with managing conditions requiring a multidisciplinary approach, happy to liaise with other agencies and often coordinate complex care packages in an informal way. They are in for the long haul, they care for their patients from cradle to grave, and they can approach assessment and care in an incremental manner. They may well resent the implication that any part of patient care is being overlooked, and may not see the need for unnecessary bureaucracy which might take up valuable time. It is important that care planning is able to take place quickly and easily in primary care in order to prevent a significant increase in workload: computerised care planning templates compatible with current primary care IT systems are feasible and urgently needed for effective implementation of care planning in primary care.

Traditionally GPs have been a 'jack of all trades' familiar with all aspects of managing multisystem diseases such as diabetes. However, General Practice is changing rapidly. Much chronic disease management is now delegated to others in the primary healthcare team. The use of a patient-held multiagency treatment record such as that used in anticoagulation, rheumatology, antenatal care and other conditions is hardly new. Primary care has an excellent track record of embracing IT templates to record details of treatment review, but under Connecting for Health, such tools are about to take a technological leap, the common clinical record potentially allowing professionals from many agencies to view and edit individual unified patient records. It is hard to think of any discipline in medicine where a complex care packages can involve as many agencies as in substance misuse, and which lends itself better to the concept of a unified, widely accessible care plan, and hard to think of any sector better placed than Primary Care to develop it.

Further information

- **Care planning practice guide, NTA August 2006** <<http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/contact/feedback.htm>>
- **e-Care planning, NTA August 2006, an e-learning tool for care planning, designed for use by service providers.** <http://www.nta.nhs.uk/publications/nta_care_plan/module/index.htm>
- **The SMMGP and NTA are keen to receive feedback on all aspects of care planning in primary care, both problems and examples of good practice, including IT solutions.** (contact Network, PCNet@SMMGP.demon.co.uk and Dr Susi Harris, NTA Clinical Team GP, susi.harris@nta-nhs.org.uk)

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'Shooting Up'

Infections among injecting drug users in the United Kingdom 2005: Summary of findings from the latest *Shooting Up* report

No time for complacency... Dr Vivian Hope and Susie Huntington highlight continuing increase in HIV prevalence, two out of five IDUs with Hep C, and increasing reported needle and syringe sharing and injecting risk behaviour, which may be related to the increase in crack injecting. However, Hep B immunisations are on the rise and the key lies in Needle Exchange Schemes and related harm reduction interventions, vaccinations, health checks and diagnostic tests... something we can do well in primary care Ed.

Infections among injecting drug users (IDUs) in the United Kingdom (UK) are a continuing public health concern. In addition to the well-recognised problems with blood borne viruses, such as HIV and hepatitis B and C, in recent years there has been increasing concern about the extent of severe bacterial infections due in part to outbreaks of wound botulism and tetanus among IDUs.

Surveillance data from across the UK on a range of bacterial and viral infections that can affect injecting drug users (IDUs) have been brought together in the fourth edition of *Shooting Up: infections among injecting drug users* [1]. The report also presents the national results for 2005 from the Unlinked Anonymous Prevalence Monitoring Programme's (UAPMP) survey of injecting drug users

in contact with services, which recruits around 3,000 injectors from across England, Wales and Northern Ireland each year.

“The main finding of the report is that the prevalence of HIV infection among IDUs in England and Wales has continued to increase.”

The main finding of the report is that the prevalence of HIV infection among IDUs in England and Wales has continued to increase. The prevalence among current injectors (those who reported injecting in the four weeks prior to taking part in the survey) in England and Wales in 2005 was 2.1%. This is the highest level ever seen among this group since in UAPMP survey started in 1990. It indicates that the increase in HIV prevalence among current IDUs in England and Wales that had been seen in recent years [2] has continued. In London the HIV prevalence among current IDUs in 2005 was 4.3%, which was similar to that at the beginning of the decade. Elsewhere in England and Wales the prevalence was 1.6%, which is more than twice the prevalence seen in 2004, and was the highest HIV prevalence ever seen in the UAPMP survey among current IDUs in England and Wales outside London. Combining data for 2004 and 2005 the prevalence of HIV infection among IDUs attending services in Northern Ireland was 2.0%.

Overall, more than two in five IDUs in the UK have been infected with hepatitis C. In 2005, 42% of the current and former IDUs who took part in the UAPMP survey had antibodies to hepatitis C (anti-HCV), which is similar to that seen in 2004 (41%).

The hepatitis C prevalence in England was 44%, however, there were marked regional variations from 20% in the North East to 55% in London and 58% in the North West (data from 2004 and 2005 combined). The prevalences in Wales and Northern Ireland were lower than most of the English regions: combining data from 2004 and 2005, hepatitis C prevalence in Wales was 18%, and in Northern Ireland it was 28%. Increasing the proportion of injectors with hepatitis C who are aware of their infection is one of the aims of the *Hepatitis C Action Plan for England* [3]. While most IDUs who took part in the UAPMP survey reported ever having accepted the offer of a test, of those who were infected with hepatitis

C in 2005 almost half were unaware of their infection, compared to three-fifths in 2000.

The proportion of IDUs reporting uptake of the hepatitis B vaccine has increased markedly in recent years with almost three-fifths now reporting uptake. However, there is evidence to suggest that the prison vaccination programmes are probably an important factor in this increase.

Elevated levels of reported needle and syringe sharing have been seen since the late 1990s, with around three in ten IDUs currently reporting this. There is evidence that the injection of crack-cocaine, which has become more widespread in recent years [4], is associated with higher levels injecting risk behaviour and prevalence of both HIV and hepatitis C infection. The underlying factors for these differences are not clear, but they are a cause for concern.

A number of recent studies have led to increasing concerns about the role that the environments where injecting events occur can have on injection hygiene and practice [5]. Recent findings also indicate that groin injecting, which is particularly risky, is probably becoming more commonplace and acceptable [6].

Needle exchange (NEX) schemes are a key service for reducing infections and maintaining good injection hygiene through the provision of sterile injection equipment, advice, and related interventions. The data presented are considered in the context of the results of the recent National Audits of NEX [7, 8]. The results of these audits indicate a great diversity across the UK in the range of injecting related equipment available, in the provision of other harm reduction interventions, and service accessibility.

The report includes recommendations for commissioners of drug services in line with the aims of the national drug strategy [9]. Priority should be given to preventing the spread of infections among IDUs and reducing the harm that these infections cause. The report recommends that this should be through continuing the development of high-quality NEX services for those unable to stop injecting; and ensuring that all services working with IDUs, provide information and practical advice on safer injecting practices, onsite vaccination

services, easy access to health checks, treatment for injection site infections, and diagnostic tests for hepatitis C and HIV.

“...continuing the development of high-quality NEX services for those unable to stop injecting; and ensuring that all services working with IDUs, provide information and practical advice on safer injecting practices, onsite vaccination services, easy access to health checks, treatment for injection site infections, and diagnostic tests for hepatitis C and HIV”

In England the recently revised *Models of Care* [10], which provides a framework for the provision of treatment to drug users, sets a clear structure for the provision of all of these services across the range of service providers working with drug users.

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Good news for hepatitis c treatment



New NICE guidance approves treatment for mild to moderate hepatitis C, but all is not rosy in the primary care PCT back yard where a public health time bomb awaits...

SMMGP welcomes the extension of the current NICE technical guidance issued in August 2006, which gives patients affected by mild to moderate disease the opportunity to be treated during the early stages of hepatitis C, before measurable damage occurs to their liver (1). This change to the guidance is welcomed, as it offers increased access to treatment for those with hepatitis C (prior to this NICE advised that only those people with moderate to severe symptoms were to be treated (2)). It is also now recommended that the decision to treat early should be made by the patient after full discussion with the treating specialist. The decision to treat need not depend on having a liver biopsy in all cases, a procedure that may have acted as a barrier to treatment for many people. Also people who continue to inject are no longer excluded from treatment.

Treatment of hepatitis C with pegylated interferons, ribavirin and alfa interferon is successful in 40-80% of cases. The success rate is dependent on a number of factors, including genotype, age, and alcohol consumption. Between 0.4% and 1% of people are infected with hepatitis C in England and Wales.

But all is not rosy with hepatitis C in primary care and PCTs

But all is not rosy! Out of the total population infected only about 67,000 (10%) have been diagnosed as HCV antibody positive in the UK (3) and only about one in 20 receives treatment each year (4). Of the total number infected this treatment rate falls to only 1-2% (5) Unfortunately, the new NICE guidelines fail to discuss the potential benefits from screening and testing people, there is

no mention of the role of primary care in managing patients with HCV infection and there is little information on how the guidance should be implemented in practice. However, as the All Party Parliamentary Group on Hepatology (APPGH) point out. Hepatitis C represents a public health problem time bomb in the UK (6).

“Hepatitis C represents a public health problem time bomb in the UK (6)”

We know that the current understanding of hepatitis C is poor, both in the general population and in primary care (7, 8). Screening, testing, diagnosis and onward referral for treatment (and hence awareness of the NICE guidance) is limited by this poor knowledge base. Additionally, we know that PCTs have not yet fully implemented the Hepatitis C Action Plan for England which stated, “Chief executives of primary care trusts should be able to demonstrate that there are adequate services and partnerships at local level to enable models of best clinical practice to be followed, as set out in this Strategy for England.”(9). Results of the APPGH survey showed a 63% response rate and that the strategy had only been implemented effectively by just 16 PCTs (8%), to some degree by 107 PCTs (56%) and not at all or minimally by 68 PCTs (36%). Only 64 of the responding PCTs (34%) have a protocol in place for the testing and/or screening for hepatitis C, and only 49 PCTs (26%) have a process in place to monitor treatment (such as how many patients are receiving treatment, its success rate, serious adverse events, how and where it is delivered and any delays encountered in delivery) (10).

Despite the fact that HCV is moving up the political agenda with current NICE guidelines recommending more patients having access to HCV treatment, funding limitations (including the infrastructure to administer treatment) continue to restrict treatment in practice. With so many PCTs in budget deficit, it seems that it will be difficult for them to accept the initial cost implications to the local healthcare economy despite an awareness of the likely cost implications of severe liver disease in 20 years time if HCV goes untreated.

Improving practice in primary care

In short, there is much work to be done
...continued overleaf

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in primary care to improve on the current situation. There are a number of things that we need to do first before we can expect to see the new NICE guidance fully implemented. We need to:

(1) Improve knowledge amongst healthcare professionals in primary care

- Improve the knowledge base in general practice by improving training for all undergraduates and postgraduates.
- Increase the hepatitis C element of the RCGP Certificate in Drug Dependency parts 1 and 2 by developing a separate 'e-module' for part 1 relating to HCV infection.
- Increase the role of consultants in helping to raise awareness of the NICE guidance amongst local GPs.

(2) Identify the large pool of patients who are currently undiagnosed

- Increase screening and testing for HCV.
- Distribute the proforma to help with what to cover in the pre-test discussion before testing patients for Hepatitis C is already available on the RCGP website www.RCGP.org.uk
- Target the huge number of patients with chronic hepatitis C who are currently undiagnosed.
- Ask all registered patients about past and current drug use (about 90% transmission through injecting drug use but some through 'snorting')
- Recognise other risk factors (e.g. born in a developing country; blood transfusions before 1991 or abroad; tattoos) and offering testing.
- Offer testing to all patients with abnormal liver transaminase levels even in the absence of obvious risk factors.

(3) Improve knowledge amongst patients

- Highlight the success of the new treatments and the fact that it is not always necessary to have a liver biopsy through awareness campaigns.
- Consider advertising in surgeries to encourage testing of at-risk patients, without discrimination, after appropriate discussion and assessment.

(4) Complete the development of RCGP guidance for the management of hepatitis C in primary care

- This is due to be published towards the middle of 2007 but is currently available in draft form for comment (NB if you would like to comment please ask us for a draft).

The need for more structured multidisciplinary working patterns

Only a fraction of people diagnosed with HCV infection are referred on and an even smaller number pass through the system for treatment (11). New structures of working will be required to improve upon this situation. The development of clinical networks, as used in the management of cancer and HIV is vital, will encourage good communication and knowledge sharing between primary and secondary care. Nurse specialists already have a key role in some areas and this could expand.

Conclusion

The NICE guidance effectively makes treatment available to all who want it, assuming there are no contraindications. However, the patient's perspective is important and treatment should not be imposed on anyone who does not want it; equally treatment should not be denied to anyone who wants it (7).

So, in summary, the change in the NICE Guidance is welcome, but there is much that can be done and needs to be done in primary care before they will be implemented.

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Dr Chris Ford SMMGP Clinical Lead
Kate Halliday, SMMGP Associate Advisor

China Needle Exchange News

CHINA Needle Exchange and Methadone Treatment Expanding Rapidly

The Ministry of Health in China reported it intends to increase by 300 the number of needle exchange facilities by the end of the calendar year (there were only 91 such services at the end of 2005). It "cited drastic declines in the number of addicts who shared needles in the areas where clinics operate as the impetus for the wider implementation." The Ministry also "plans to open more methadone clinics to assist addicts in fighting their addiction." (EIU ViewWire Select, October 9, 2006) According to the Xinhua news service (Oct 19), China opened 206 methadone clinics between July and September this year bringing the total to 307. The methadone treatment program was initiated in 2003, and now covers about two thirds of all China's 31 provinces, autonomous regions and municipalities.

This represents an important and interesting shift in China's policy. Very glad to see they have dropped Mao Tse-Tung treatment policy which was offering to shoot people if they did not stop. But disturbed to see this policy congratulated in a recent article in Druglink by Theodore Dalrymple who also went on to describe Mao as 'the greatest drug-addiction therapist in history' ('Poppycock by Theodore Damrymple' in Druglink vol 21, issue 6 page 14). BUT don't miss the alternative view 'A fine romance' by Peter McDermott on page 15.

Chris Ford

Working with drug users who are injected by other people



Charlotte Tompkins, Laura Sheard and Nat Wright have conducted a fascinating study on women users injected by other users, resulting in clear and useful clinical implications. On the back of our article on *Shooting Up* and on increasing HIV and Hepatitis prevalence and risky injecting practices, this is a must read. Ed.

Overview

During GP surgeries or clinics in primary care based treatment services, injecting drug users, especially women, frequently reported needing help when injecting and were often injected by other people. We decided to explore this, particularly with regards to the implications for clinical practice. We interviewed 45 women users, recruited from various settings, including primary care services. A number of interesting findings were identified, resulting in recommendations for primary care and practice.

Findings

We found that being injected by someone else as an initiation into injecting practice (i.e. the first ever time women experienced injecting) was common. Whilst this is not particularly surprising, many continued to be injected as they were fearful and lacked knowledge, skill and confidence to prepare and self inject drugs. Interestingly, most women had to exchange drugs as 'payment' for being injected and they were often injected after their injector had self injected.

However, being injected by heavily intoxicated injectors increased their risk of physical harm. Most women were confused about the health risks of being injected but felt wary of being deceived when being injected. We found being in a state of opiate withdrawal placed women at increased risk as they went to great lengths to alleviate withdrawal. This included being injected by users who they did not know. Watching what the injector was doing whilst being injected had a number of benefits regarding safety and preventing deception. Being injected was a common feature of many women's heterosexual relationships. This sometimes placed them at an increased risk of abuse and physical injecting related harm. However, being injected within the context of a mutually supportive sexual relationship appeared to minimise the risks from injecting. The consequences of being injected are discussed in further detail in our recent article (1).

Key messages for harm reduction

This study helped to understand the receiving of injections and the associated risks. A number of practical harm reduction recommendations arise which should be closely considered by all primary care services working with drug users who are being injected. Some recommendations are relatively straightforward and should be easy to implement into daily practice. These recommendations are underpinned by a continual emphasis on harm reduction. There should be advice and safer injecting information for injection recipients who approach primary care services. Service personnel working with them would benefit from increased awareness and training regarding this important issue.

Working with injection recipients in primary care

We propose a number of recommendations for clinical staff working with users who are being injected. These include:

- **Encourage self injecting** if they are experiencing a greater harm from being injected
- **Not to be injected by people they do not know or trust**
- **Taking responsibility for stopping their own blood flow** from their

injection site(s)

- **Preparing their own drugs**
- **Watching what the injector is doing** whilst preparing and injecting
- **Communicate with injectors** when being injected
- **Negotiate with injectors regarding the order of injecting**
- **Stress the independence and economic advantage of self injecting** when compared to being injected
- **Provide staff training regarding the reality and complexity of peer injecting**
- **Develop empathic and trusting relationships with users** to confidently discuss peer injecting
- **Communicate the principles of choice and assertiveness** skills to those receiving injections
- **Provide harm reduction information** detailing the increased **HIV, hepatitis and bacterial infection risks** and the possible increased **risk of damage to the circulatory system** from being injected
- **Consider providing explicit instruction** on injecting practice
- **Explore the social situation of injecting** for those who inject others to assess the injector/injectee relationship
- **Provide practical harm reduction information** for those who inject others about the safest and most considerate techniques to use
- **Encourage regular injectors:**
 - ◆ to **take time and care** when injecting others
 - ◆ to **communicate** with the injectee
 - ◆ to think about their **withdrawal/intoxication status** when injecting others

Charlotte Tompkins, Laura Sheard and Nat Wright

Leeds West Primary Care Trust based at the Centre for Research in Primary Care, University of Leeds. For more details about the work, please contact Charlotte Tompkins c.tompkins@leeds.ac.uk

Reference:

¹ Tompkins, CNE., Sheard, L., Wright, NMJ., Jones, L. & Howes, N. (2006) 'Exchange, Deceit, Risk and Harm: The Consequences for Women of Receiving Injections from Other Drug Users.' *Drugs: Education, Prevention and Policy* 13(3): 281-297.

Practice based commissioning

PBC is here to stay. Many of us may not really understand it in general, let alone its significance for drug services. It has even been suggested that it will not be used to develop drug services. This has already been proved wrong. Here we are publishing the experiences from two localities where it has been used. – one from Clive Jekyll, Adult Treatment Lead in Northampton and the other from Steve Skinner, Joint Commissioning Manager in Lincolnshire

Since 2004 the Department of Health (DH) has been encouraging GP practices to investigate the potential posed by Practice Based Commissioning (PBC). In this latest DH initiative, practices are encouraged to investigate the services needed in their locality and then commission, with the PCT playing the role of banker. By a strange coincidence exactly the same has been attempted from the start of the Drug Strategy in 1998 and it has been a hard uphill struggle for all concerned. In his introduction to the DH guidance on early wins and tips the National Clinical Director for

Primary Care, David Colin-Thomé, summarised the expectations under the new system:

- More services to be provided in community settings
- More services to be provided by practices
- Longer opening hours for practices
- Greater use of a wider range of providers
- More convenient services for patients and
- More integration between health and social care

The document also suggests that “involving patients is crucial to maximising success in practice based commissioning” (1). These are milestones and aspirations that have populated treatment plans across the country for the last 8 years. Now they are mainstream goals which everybody has a stake in attaining. As a consequence it is an ideal time for DAATs and Shared Care Development Workers to promote the virtues of “joined-up” working and enable local communities to address their own health concerns. **Clive Jekyll**

1. Northamptonshire PBC Model

In Northamptonshire the DAAT has striven to engage all the health and social care partnerships in multi agency working, enabling service users to engage with a wide range of interventions applicable to need. Part of this process has included working with Wellingborough GP practices attempting to scope local needs. With one already engaged in Shared Care, three local practices recognized substance misuse as a significant problem within their practice populations, a factor borne out by data from both the DIP program and generic services in the area. A DAAT needs assessment, carried out at the start of this year, also identified long waiting times (over 50 days in some cases) and long retention in individual treatment interventions as providing the grounds for such an approach.

Discussions began, to agree in principle what could be delivered in Wellingborough. Immediately it became apparent to both parties that there were quite different expectations of treatment delivery, borne by the disparate levels of experience. The culmination of these initial contacts was a paper to the local PBC Board, on the local multi-agency partnership model, and supporting information relating to resources and finance. With no real skills in this area the local PBC Board have welcomed the input from DAAT, while the latter have invited a PBC Board representative on to the planning forum for the Multi-Agency Partnership. This has presented the opportunity to steer the direction of travel by highlighting a core care team approach, supported by integration with local socio-centric services, providing access to a range of services across the whole Models of Care framework.

The practices, by comparison, have more understanding of the services needed to support rehabilitating drug users in the local community. This is a win-win situation for everyone. Patients going to their doctors feel they are being listened to and their needs properly assessed while practices don't feel unsupported when a potentially challenging patient enters the surgery. The DAAT and the wider partnerships are able to pool resources in order to provide a strategically cohesive treatment system. This approach negates much of the duplication in service provision that historically has blighted service provision, not only locally, but also nationally.

What Northamptonshire DAAT intends to achieve in partnership with Wellingborough is an integrated service that is:

- Accessible and equitable to all who need it
- Provides a range of services that can be tailored to the needs of the individual while reflecting the needs of the community
- Enables seamless care from primary care to secondary care and back
- Contiguous availability of community based services, e.g. pharmacy, dental care, housing and employment
- The ability to outreach to more isolated patient populations
- Integrated information systems that enable and empower patient engagement rather than hinder

All these reflect and enhance the targets indicated by David Colin-Thomé, National Clinical Director for Primary Care.

While PBC means in theory there may be access to additional funding it is important to get this right and to ensure that this finite resource is targeted at areas that cannot be covered by the Adult Pooled Treatment Budget or any other funding currently utilised for drug treatment. This will be relatively easy to do as practices or localities are required to “identify ... (local) ... health needs ... and the appropriate services to be provided ... to develop their own local delivery plans” (2).

For instance, this may make it easier to employ a GPwSI for a locality; or to have an integrated IT system and information protocol based on locally accepted criteria.

To take forward this strategy the DAAT has sought support from all the main partnerships in the county. This has been granted and the Team can look forward to a period of sustained development which will culminate in the launch of a structured service that puts clients at the centre of the treatment planning process, while taking advantage of the new direction of primary care service expansion. This is an exciting and defining period for all concerned in the commissioning of drug services

Clive Jekyll

Adult Treatment Lead, Northamptonshire Drug and Alcohol Action Team

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2. Lincolnshire PBC Model

In Lincolnshire the Primary Care Trust (PCT) has proposed the formation of eight Practice Based Commissioning (PBC) clusters covering the counties 646,645 population. It is fair to say that these arrangements are in their infancy and each of the proposed clusters is at a different stage of readiness. Despite this one cluster has already expressed their interest in a practice based commissioning service model for drug users and it is expected that further interest will be expressed in year by other clusters as they grow in maturity.

As a pilot project the Drug and Alcohol Action Team (DAAT) has agreed to support the cluster to develop a suitable service model in year. Evaluation of the current Lincolnshire shared care scheme by the SMMGP has highlighted a number of strengths including committed, well trained GP's, high quality treatment, examples of high quality multi-agency working at a practical level, a high level of commitment from local practitioners, a well organised and growing pharmacy scheme and good training provision within each profession. Although there are clear strengths in the current scheme it is generally felt that services could be made more efficient through better organisation. It is hoped that the development of the proposed model will strengthen leadership and organisation at the clinical level. Practice based commissioning is being hailed as 'the best vehicle for ensuring clinical leadership from primary care professionals in redesigning services' (DH,2006).

The cluster comprises of thirteen surgeries with an approximate list size of 81,649 (12.5% of the county population). An established GP with a special interest (GPwSI) will become the named champion for the pilot, representing the project at a county wide level and leading on the development of service governance. Key features of the pilot will be:

- Separate contractual arrangements defining the operation, financial input and performance management of the project.
- Management and accommodation costs are included to support delivery within the cluster area.
- Two specialist clinics staffed by GPwSI and specialist nurses from local treatment provider at locations convenient for patients.
- Agreement of practices to treating drug users and formal arrangements for treating patients from practices that

opt out of prescribing. Nursing support to be provided by a local specialist treatment provider and a local payment scheme will be available for those practices involved in prescribing.

- Drug screening and blood borne virus testing via local service protocol.
- Assertive follow up of all patients presenting to the service with the aim of preventing early drop out and improving service retention.
- Sustained and continuing one to one relapse prevention work until abstinence or stable maintenance is achieved. Access to structured day service group work program in various locations for wrap-a-round support.
- Clear lines of communication using established primary care structures and interface with DAAT partnership groups.
- Localised input into resource allocation improving targeting of services. Close liaison with relevant agencies and allied professionals, in particular Pharmacists.
- A program of training for GP's and other practice staff in the management of substance misuse will be delivered in county by the DAAT training team. This will include the availability of the RCGP part one training course for general practitioners and CPPE training for pharmacies. Drug awareness and brief interventions training will also be available for practice staff.
- Development of a database compliant with the National drug treatment monitoring system and capable of electronic upload.

The underlying principle is to ensure delivery becomes an integral part of the whole treatment system commissioned by the DAAT partnership and the benefits that PBC promises gives added value to existing service provision maximising the benefit to patients. All parties involved have acknowledged that ongoing support, flexibility and commitment will be important to achieve the defined outcomes.

Steve Skinner,

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Heresy, dogma and the Inquisition

Supervised consumption in the real world part II

A second part of an article continuing from last issue on using supervised consumption as a positive therapeutic tool for dose induction and assessment. Ed.

In a previous article I discussed the (often heated) debate about the role of supervised consumption of opiate substitute medication and questioned some of the dogma surrounding the indications and reasons for its use. I likened this in some degree to the Inquisition, in that people perhaps adhered to the dogma more out of fear than the persuasiveness of the reasoned argument. In summation I proposed that many, if not most of us now relate to the use of supervised consumption as an aid to dose induction and assessment as much, if not more, than as a barrier to diversion of prescribed medication.



Dose induction and assessment

This is the process by which the initial dose (usually 30-40mls for methadone and 4-8mg for buprenorphine) is increased under Supervised Consumption until stability of drug use and lifestyle is achieved. Community dose assessment (at a local pharmacy) should be the norm for the vast majority of patients in the early stages of prescribing *ie approximately the first 3 months*

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My aim in this second article is to highlight the distinction between 'Dose induction' and 'Dose Assessment' for **METHADONE**. The 'Dose Induction' period refers to the first 2 weeks of prescribing.

Please remember:

- Methadone induction deaths are rare
- Most deaths occur in the first 2-3 days
- In excess of 20% of all deaths in treatment are within 2 weeks of commencement of prescribing
- Most deaths occur during sleep – *during induction avoid patients taking methadone during the evening. Peak methadone level is 2-4hrs after a single dose*
- Daily assessment by a pharmacist using Supervised Consumption is the best safeguard against over-sedation in a patient going undetected
- Patients should be informed of 'increasing effect of a dose' as steady state is achieved so that they do not excessively 'top up' with street drugs

Dose induction of methadone:

Because some individuals may accumulate methadone in tissues unpredictably, initial monitoring using methadone needs to be more rigorous but many believe this should not prevent us moving some patients to significant doses more quickly, when clinically indicated.

Managing increments subsequent to initial dose induction:

This has been covered comprehensively elsewhere eg RCGP Methadone Guidance Sept 2005.

Community dose assessment according to patient 'comfort'

Dose titration historically has tended to concentrate on physical withdrawal symptoms, the target of this type of dose assessment being the ablation of these symptoms. If we only use physical symptoms to determine the final maintenance dose then we may leave our patients with psychological symptomatology and may not give them doses which adequately facilitates the cessation of daily opiate use. These symptoms are commonly regarded as **dysphoria, insomnia, anxiety and craving**. Continued use of drugs **other** than opiates and requests for alternative prescriptions eg cocaine, crack/cocaine, anti-depressants, benzodiazepines and related hypnotics/anxiolytics ('Z' drugs eg Zopiclone) are often influenced by under-dosing with opiate substitute medication.

Service user attitudes

Here I believe, is the real challenge. Many of us know that even if we are clear about the use of supervised consumption and higher doses our patients are not and many resist higher doses. With appropriate use of supervised consumption, patients can determine their maintenance dose, if not actually the starting dose and how they progress to it. We need to 'sell' the benefits of this to patients if we wish them to accept doses at which they are more 'comfortable' and which are linked with improved retention in treatment.

A prescriber checklist

If patients are asked to judge their own comfort, how do we judge their comfort and reflect this to them? Below I propose a set of criteria. I use them to highlight when I think someone is (for understandable reasons) under-dosing themselves:

Moving on from supervised consumption

In my experience some people stay on supervised consumption for long periods. Perhaps prescribers are unclear of why they are using it or it has not been reviewed adequately and patients choose not to rock the boat. I think it is our responsibility to move patients from

'Patient comfort' as a guide to dose assessment:

Persistence of these may indicate a need for dose increase:

- Significant street drug use
- Craving
- Dysphoria/low mood, insomnia or anxiety – *if assessed as probably the result of tolerance to opiates. Low mood clearly has to be distinguished from depression*

supervised consumption through a hierarchy of dispensing arrangements, starting with daily dispensing at a named pharmacy and moving to less frequent dispensing as appropriate, according to demonstrable progress.

In summary

Supervised consumption is a powerful tool and of great benefit to patients. It gives prescribers the reassurances about safety which they need and it gives patients more easy access to the sort of dose at which they feel comfortable. We need to use it consistently in a way which utilises its strengths in the belief that it will gain acceptance because of the palpable good it does as much as the possible harm which may occur in the absence of its use.

Nigel Modern,

Lead GP (Substance Misuse)
Birmingham Drug Action Team and Heart of Birmingham Teaching PCT



Dr Fixit on being drug and alcohol free

Dear Dr Fixit

John aged 38 years has been a patient of mine for 5 years. When he presented he was using a cocktail of mainly heroin and cocaine. He also drank mainly in binges and used periodic benzodiazepines. After a turbulent first few months he settled well into treatment, using both counselling and a maintenance prescription of 140mg methadone mixture. He looks well, has started a back to work programme and he says he is not using on top of his prescription. He has not used benzos or any other drug for over a year and his urines confirm this. He is also pleased that he has not had a binge on alcohol for this period. He now feels he has reached the point in his life where he would like to be drug and alcohol free.

I feel confident to support his maintenance but feel anxious knowing the evidence to support him to become abstinent. He seems to have little memory of the mess he was in when he presented and little acceptance of how well he is now doing. But I really want to help him become drug-free as that is his choice – how can I best do that?

Answer provided by Dr Gordon Morse

Abstinence from drugs is much more than a state of absence of chemicals from your brain, it is a spiritual life choice. John is progressing well with his alcohol and benzo use, and clearly his methadone prescription has been extremely effective: there is no practical reason why he should not continue on that indefinitely, and good evidence that in so doing, he is avoiding the risks (of relapse on opiate naivety) attendant with detox.

But perhaps John, like many of our patients, will tire of his dependency on a drug, a pharmacist, a doctor, a drug service, and the daily fear of this life support system being interfered with or changed in any way. And no matter how well his drug use is being addressed by his prescription, his alcohol consumption may need to be dealt with. Abstinence addresses all of these concerns. Abstinence does not tarry in greyness, it is simple, refreshing, crystal clear and unambiguous. It says: "I am a rotten drug

user. Maybe other people can do this, but I can't and it is killing me. I have to stop, to survive." Rather like the vegetarian takes an arbitrary decision to not eat meat, so the drug user arrives at a decision that he/she just has to stop using all mind affecting substances.

From there on, the process of "recovery" varies according to the route chosen. Many just do this themselves. Having been through a thousand clucks before, they know what they have to do. Others will adopt the prescriptive paths of NA/CA/AA – paths that hundreds of thousands of people the world over, owe their lives to. Others still will be grateful for the orderly therapeutic approach of rehabilitation programmes, perhaps beginning with an intense residential treatment.

But this is not an option for the faint hearted: abstinence demands a volt face of attitude most of all it demands the acceptance of responsibility for one's life. How a detox is done is supremely irrelevant, even though it is the one thing that concerns the patient more than all else. Abstinence is (by definition) NOT about drugs, it is about dealing with life's vicissitudes, and appreciating the life experience, not the chemical experience. This is not a religious notion, it is simply to accept one's humanity.

Dr Gordon Morse, GP Medical Consultant to Clouds House, Trust Specialist and Lead GP Clinician for West Wiltshire Specialist Drug and Alcohol Service, RCGP Regional Lead.

DRINK DIARY –

Next issue we will look at a Drink Diary which is a good way of looking at your drinking or your patient's drinking and assessing what – if anything – needs to change.

There are many examples of drink diaries but an easy one to print off is on the Aquarius website (www.aquarius.org.uk in About Drinking Problems menu).

Holiday Script Law Change - Home Office

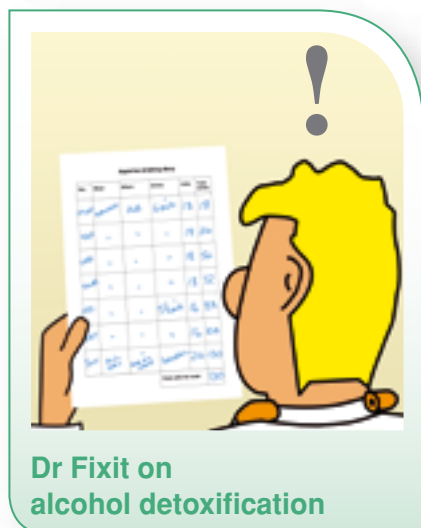
As of the first of January 2007 the "open general license" which applies in the case of methadone to all scripts under 500mg will be extended to cover all scripts lasting less than 1 month. Licenses will only have to be applied for for scripts lasting more than 1 month. This means applying for licenses will be a thing of the past for most

people. A prescribers letter is still recommended as before. Good news for all.

It should be noted that this, as before, only applies to export from the UK. Patients are strongly advised to check with the relevant embassy the regulations regarding importing controlled drugs into the country they are intending to visit.

Patients should also be aware of new regulations regarding the carrying of liquids in hand luggage. Methadone tablets may be needed for long-haul flights unless it can be proved to be 'essential medication'.

Dr Fixit on alcohol detoxification



Dear Dr Fixit

John aged 44 years came to see me for a health check. During the check I asked him about his alcohol consumption. We worked out together that he was drinking about 130 units a week (mainly as 7.5% lager). He seemed keen to address his problem and was able to see that his drinking was causing social and economic problems. He had a clear motivation to change his drinking pattern.

He had previously been through two self detox's and managed to have a period without drinking of two months, but not more. He had always relapsed through events and changes in his social life, which stressed him, and made him drink, he feels. He wants to see if there is anything he can do to address this.

John is clearly drinking every day at levels considered dependent drinking levels. He described himself as having a dependent pattern but had never been to any alcohol service despite being referred to a specialist service, this was his first experience of asking for treatment for alcohol.

He is however not keen to be referred to specialist services and would like to do a community detox, but I do have access to an alcohol worker who will come to the surgery.

How should I proceed? At these levels

should I insist he goes to the specialists or could I attempt a home detox with the help of the alcohol worker?

Answer provided by Jeff Fernandez

The level of up to 200 units a week are what is at present, the level most GP's (in Islington, London, where I work) on the whole, feel safe to prescribe a detox regime with chlorthalidopoxide (Librium). Clomethiazole (Hemeverin) should NEVER be prescribed in the community because of the possible respiratory complication with using Hemeverin. Chlorthalidopoxide is the safest detoxification drug to use in general practice.

Therefore, if the GP is confident in this field they may feel they could take a patient with higher levels of dependent drinking. However, cases with high levels, in the region of 150 plus a week, with any other psychiatric/medical condition such as history of withdrawal fits, alcohol liver disease or severe depression or psychosis, I feel a referral to a specialist service (tier three) should be sought, if indeed, only for advice on a care-plan.

Any GP or clinician in this area should ask what would work? Anyone arguably will be able to take medication and detox but the outcome of achieving 'dry' time is very important to consider. What would be successful in this area? If there is no previous history of achieving 'dry' time, a reduction plan to reduce to under 100 units a week (aim for 70 really) should be tried. This will increase insight, awareness of patterns and importantly identify psychological triggers for alcohol. These concepts need to be highlighted as areas to work on through the detox and beyond in relapse prevention. To ignore these important psychological markers will compromise the ability to stay alcohol free.

In John's case this has arguably been achieved through two self-detoxes, which have been followed with some successful alcohol free time. A detox for this type of client with previous successful detoxes makes John a good potential candidate and periods of not drinking again is a strong possibility. But what is important is structured relapse prevention afterwards. In this case, the alcohol worker (tier two) available can provide it to the GP, if not advice should be sought as to where this can be attained from a specialist service. It is often not detoxing which is hard but staying 'dry', as most ex-drinkers would agree with.

Therefore in this case, insight and an experience of what is involved in a detox is arguably, already there and the units per week are less than 150 per week. This is not an ideal candidate but a good one potentially, since the detoxes achieved by John were followed by 'dry' time. Therefore, in my clinical opinion: a detox regime should be prescribed with follow-up for relapse prevention and on-going work co-ordinated by the alcohol worker.

Jeff Fernandez, Specialist Nurse, Alcohol/Drugs Islington PCT



Dear Dr Fixit

I have a patient on methadone 100mg daily, well, stable and doing heavy shift-work at a tyre factory where he does hard manual graft for 10 hours at a time and loves it.

When he is doing day shifts he takes his methadone before he starts work and all is well. When he does night shifts, if he continues to take his methadone in the mornings, he is convinced that his methadone "wears off" before the next dose and he "has to use heroin" on top. We have a good relationship - he knows that he has no need to lie to me - that I will not punish him and that I will continue to prescribe - I have offered to give him more methadone but he doesn't want it and he has tried split dosing which he says doesn't work either. His shifts unfortunately are not predictable so he tells me that the reason he continues to use heroin albeit infrequently is purely because of this.

Is there any sense in this? Is it just a psychological thing? Is he kidding me? Obviously I can just resign myself to it,

but it irritates me because I can't make any sense of it!

Could you offer any advice please?

Answer provided by Chris Ford and Kim Wolff

This is all to do with diurnal rhythm - your hormones do amazing things when you are on shift work.

Environmental cycles, such as the light-dark cycle, provide information used by the internal biological clock in the brain (hypothalamus) to synchronize the biological systems. Usually our biological clock activates body systems to wake up in the morning and gradually slow down again in early evening.

In persons whose work schedules include shift work the sleep-wake cycles is different to normal and this has an impact on biological systems.

Both daytime and night-time work is associated with perturbed endocrine functions which could explain certain health problems and sleep disorders (Weibel et al, 1999). Most people feel "off colour" at the start of a new shift pattern. This is worse if the shift pattern changes regularly and is short term. This is a true biological effect.

Thus time of dosing with methadone may be the key to success when working shifts. I would start by asking if he wants to stop heroin (he may not).

If he does then I would increase the dose by about 20mg and ask him to take his methadone just before he goes to work on the night shift (instead of in the morning). He may find that on day one of the night shift the dose should be split to take half in the morning when he gets in before going to bed.

It would be useful to know the timing of the shift and how they are split (over how many days etc). Splitting the dose may also help – but try a 60:40 split (taking the larger dose before going to work).

I would try and establish a pattern over at least 5 days. I have had a few shift workers over the years and several of them have had a similar problem for which increasing and splitting has worked.

Anyone got any other thoughts?

Dr Chris Ford – SMMGP Clinical Lead & Network Advisory Editor

Kim Wolff -Senior Lecturer in the Addictions, Head of Taught Graduate Studies, Kings College London

Methadone and exercise

1. It is important to prepare for strenuous exertion

Strenuous exercise represents a physical stress on the body that challenges homeostasis. The body responds in a series of ways, most obviously through changes in the Autonomic Nervous System (ANS) causing an increase in body temperature, heart and breathing rate. The speed of recovery back to a resting state is related to the current degree of fitness.

Other more complex systems also respond to exercise and the Hypothalamic – pituitary – adrenal axis (HPA) is known to react to maintain homeostasis, including elevation of cortisol and catecholamines (Mastorakos et al, 2005)

2. Some exercise each day is beneficial

Little has been documented about the impact of exercise on the efficacy of methadone, although some pre-clinical work has been carried out: In rats for instance, it has been observed that exercise increases the concentration of endogenous opioid peptides (beta-endorphin beta). This effect had also been observed in humans and purportedly provides that "feel good" factor after exercising.

In methadone dependent exercising rats consumed significantly less methadone than non-exercising controls (McLachlan et al, 1994)!

3. Methadone dosing should not need adjustment

In humans exercise would not be expected to have a deleterious effect on those stabilised on the drug. Strenuous exercise in the unfit would be likely to cause aches, joint pains, muscle strain, stiff limbs and sometimes gastro-intestinal motility that should not be confused with symptoms of methadone withdrawal.

Kim Wolff

Senior Lecturer in the Addictions, Head of Taught Graduate Studies, Kings College London

Become an SMMGP member-make a difference

SMMGP is to become a formal membership organisation, so we can better hear your opinions and represent your views. With changes in funding and nearing the end of the 10 year Government Drug Strategy it is increasingly important that Primary Care has an organised voice within the drug treatment sector. We feel that membership will help us to consult with you more easily and allow us to provide an improved service. It will also be easier for national organisations such as the NTA, RCGP, SCAN and RCPsych to be able to consult with us and hear member views.

Membership is free of charge and all you need to is complete the form inserted in this issue and return it to us

The benefits of membership include:

- Monthly clinical updates including 'journal watch'
- Monthly policy updates
- Views consulted on the treatment field and fed back nationally
- Views consulted on services SMMGP should be providing
- Invitation to membership events
- Being part of the voice for the primary care substance misuse treatment field The more people that join the stronger the voice

At some point in the future we may

Please complete our enclosed form or at
www.smmgp.org.uk/membership

BULLETIN BOARD

Upcoming RCGP Substance Misuse Unit CPD Events for 2007

Update on: Detoxification and Methods to Maintain Abstinence

Thursday 18th January at The Royal York Hotel, York

Update on: Poly Drug Use, including Benzodiazepines

Wednesday 28th March at The RCGP, 14 Princes Gate, Hyde Park, London

Prisons and Drugs Conference

Friday March 2nd venue tbc

Secure Environments

Wednesday 7th March London Southwark Cathedral

Update on: Hidden Harm and Child Protection

Tuesday 8th May at The Globe Theatre, Bankside, Southwark, London

Update on: Update on Crack Cocaine and Benzodiazepines

Wednesday 27th June at The Palace Hotel, Oxford Street, Manchester

Update on: Dual Diagnosis

September 18th September at The RCGP, Hyde Park, London

Update on: Screening and Brief Interventions for Alcohol

Monday 8th October at the RCGP, Hyde Park, London

Update on: Prescribing for Opiate Users

Tuesday 23rd October at the RCGP, Hyde Park, London

Next Part 1 Certificate Face to Face Training day

Monday 12th February at the RCGP London

Next Part 2 Certificate starting with:

Thursday 8th February in York Royal York Hotel

Friday 23rd February in London Holiday Inn – Bloomsbury

1 day events costed at £130 for RCGP Certificate Part 1 or Part 2 holders or members of RCGP £150 for others. For more information about any of these events, or to reserve a place please contact: Jo Betterton jbetterton@rcgp.org.uk 020 7173 6095

National Conferences

March 15-16th National Drug Treatment Conference Novotel London
details from www.exchangesupplies.org

April 19th & 20th National Managing Drug Users in Primary Care Conference, Birmingham
application forms on www.smmgp.org and www.healthcare-events.co.uk, 020 8541 1399
Don't forget to get your paper, audit, poster or film in!

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Network reader survey - tell us what you think

In order to maintain and develop the quality of 'Network' and to ensure it meets the needs of our readership we are conducting a user survey. We need to know what you find useful or not about network, your ideas for future topics and identify future contributors. Please take time to fill in the questionnaire insert which is on the other side of the membership form. You can also fill the form in on line by visiting www.smmgp.org.uk/network

Thank-you for your time

Jim Barnard
Policy Officer
SMMGP

SMMGP works in partnership with



National Treatment Agency
for Substance Misuse